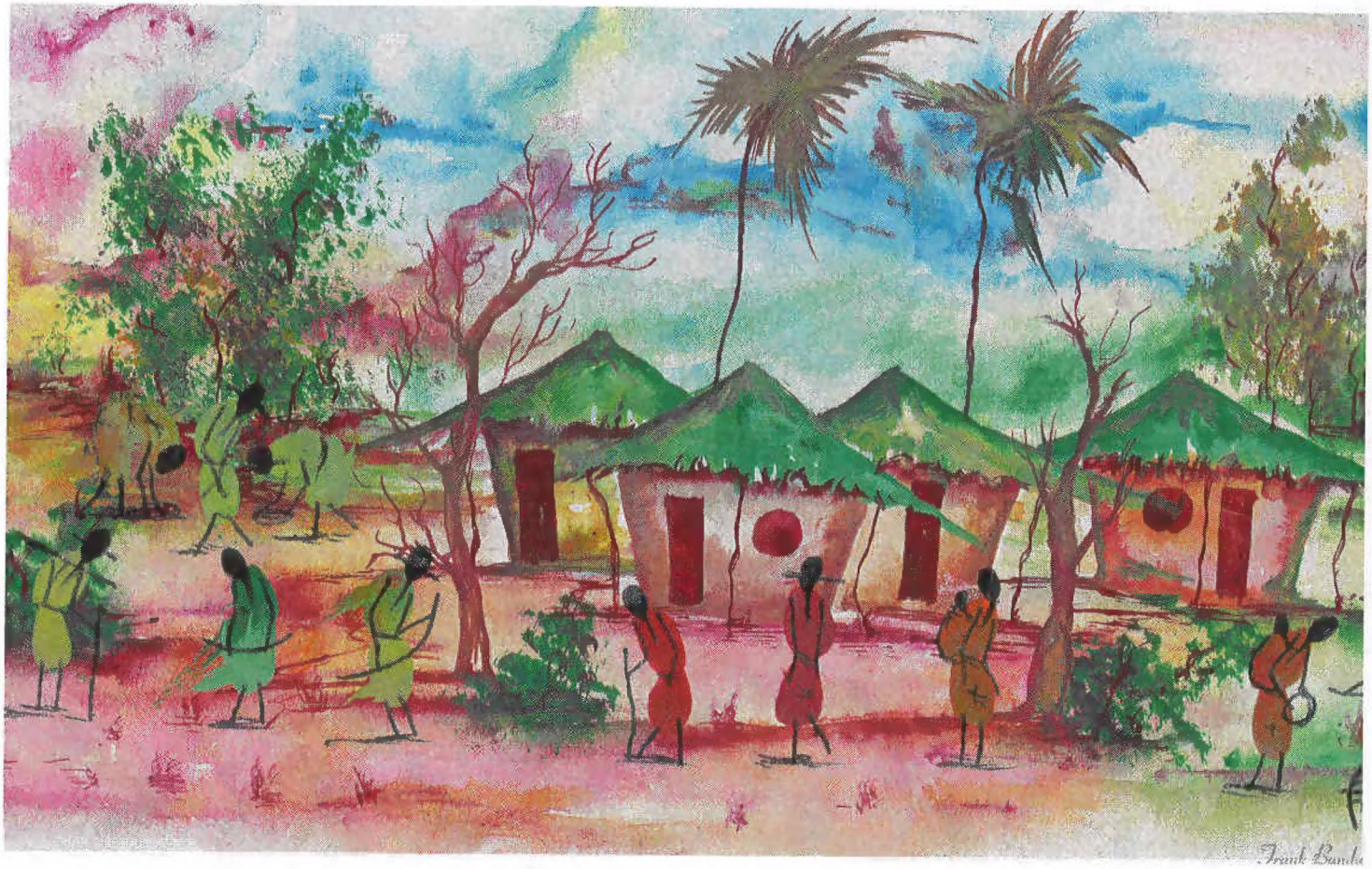

Family Planning and Reproductive Health Survey

A Baseline Survey of Selected Pilot and Control Districts in Malawi

Population and Family Planning Project
Ministry of Health and Population
Lilongwe, Malawi

Macro International Inc.
Calverton, Maryland, USA

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May 2000

This report presents the findings of the 1999 Family Planning and Reproductive Health Survey (FPRHS), which was a baseline study in selected districts in Malawi where a community-based family planning delivery system is being piloted, and in selected control districts. The FPRHS was implemented by the Population and Family Planning Project (PFPP) of the Ministry of Health and Population. Technical Assistance was provided by Macro International Inc.

Additional information about the Family Planning and Reproductive Health Survey and the PFPP project may be obtained from the Population and Family Planning Project, Ministry of Health and Population, P.O. Box 30377, Lilongwe, Malawi (tel: 726-540; fax: 724-223; e-mail: popfp@malawi.net). Further information about design elements of the survey, which was partially modeled on the 1999 Malawi Demographic and Health Survey, can be obtained from Macro International Inc., 11785 Beltsville Drive, Calverton, Maryland 20705-3119 (tel: 301-572-0200; fax: 301-572-0993).

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ACKNOWLEDGEMENTS

The Malawi Government recognizes with great concern the persistently low contraceptive prevalence rate that adversely affect the quality of life of Malawians, and is therefore committed through the activities of the MOHP to improving the accessibility of family planning services to all individuals, especially those residing in rural areas. The MOHP believes that the Population and Family Planning Project (PFPP) will assist in meeting the goal of making family planning services accessible to men, women and youths in rural areas. This report on the Family Planning and Reproductive Health Survey (FPRHS) is considered critical in marking the way forward for family planning and reproductive health activities in the PFPP districts. It provides the bench mark information that is necessary for assessing the impact of the PFPP projects. The Malawi Government wishes to acknowledge the cooperation and assistance of the individuals who participated in the survey.

The MOHP is grateful to the District Health Management teams, for accepting the study teams to collect the data in their districts and for allowing the Family Planning Coordinators and providers as well as the Health Surveillance Assistants (HSAs) to collect the data. The women who provided the data by responding to the questionnaires deserve special recognition as, without their cooperation, the survey would have not taken place.

The Ministry of Health is also grateful to the personnel of the PFPP management team for their dedication and commitment in the preparation and management of the data collection exercise. The data collection would not have been successful if it was not for the special field supervisory skills of Mr. Richmond Chinula, Mr. Benjamin Kaneka, Mrs. Grace Hiwa, Mrs. Mercy Zulu, Mr. James Kaphuka, Mr. Magombo, and Mr. Jamison Ndawala.

Lastly, but not least, we would like to recognize the efforts of Macro International, who provided the technical expertise for the design of the survey, the analysis of the data, as well as the production of the report.

I hope the report will be beneficial not only for the Population and Family Planning Project but to other stakeholders involved in the provision of family planning and reproductive health services.

EXECUTIVE SUMMARY

Introduction: The Family Planning and Reproductive Health Survey (FPRHS) had as its principal objective: to establish benchmark values of key performance indicators for the Population and Family Planning Project (PFPP) of the Ministry of Health and Population. The PFPP is designed to test the feasibility and effectiveness of a comprehensive, community-based distribution (CBD) approach to delivery of family planning services.

Survey Design and Methods: The 3 pilot districts of the PFPP include Chitipa, Ntchisi, and Chiradzulu with the adjacent districts of Karonga, Dowa, and Mulanje serving as control districts. It is expected that the CBD programme, put in place beginning in early 2000, will produce increases in knowledge and use of modern contraception by the end of 2002. A similar follow-up survey will be conducted at that time to evaluate the effectiveness of the piloted interventions occurring during the 3-year intersurvey period. Should the intervention model prove feasible and effective, it is expected that the services will be scaled-up to the national level.

The FPRHS indicators of main interest include:

- Knowledge of contraceptive methods,
- Contraceptive prevalence (i.e. current use of modern contraception),
- Source of currently used contraceptive method,
- Approval of family planning,
- Childbearing preferences,
- Knowledge of means to prevent HIV/AIDS,
- Use of a condom at last sexual intercourse.

The FPRHS was conducted by the Population and Family Planning Project with key technical inputs provided by the National Statistical Office (Zomba) and Macro International (Maryland, USA). The FPRHS was designed to yield approximately 500 interviews with women age-15-49 in each of the 6 pilot/control districts. Questions were asked about the respondent's household characteristics, personal background, reproductive history, and fertility preferences, in addition to the detailed information on her knowledge and use of the various contraceptive methods. A series of questions on knowledge and behaviors related to HIV/AIDS was also added.

Results: Response rates in the FPRHS were very good, with interviews obtained for 95 percent of eligible women. Between 500 and 631 women were interviewed in each of the 6 pilot/control districts. Women interviewed in pilot and control areas were very similar with respect to basic measures of socioeconomic status.

The results indicate that knowledge of contraceptive methods is high, with 89 percent of women in pilot areas and 93 percent of women in control areas knowing at least one modern contraceptive method. In both pilot and control areas, contraceptive pills and injectables were the most widely known methods (over 80 percent of women). Condoms were also known by over three-quarters of women interviewed.

The contraceptive prevalence rate (modern method use among married women) was nearly the same in pilot areas (24 percent) as in control districts (25 percent). Injectables were by far the most widely used contraceptive method: 14 percent of women in both pilot and control districts were using this method. In the pilot districts, injectable use was followed in prevalence by the pill (4 percent), condoms (4 percent), and

female sterilization (3 percent). In control districts, pill use was slightly lower (2 percent), condom use was the same (4 percent), and female sterilization was slightly higher (4 percent). As has been observed in previous national surveys, traditional method use is not a large component of the overall contraceptive method mix picture except in the two northern districts of Chitipa and Karonga, where use of withdrawal is quite commonly reported.

As expected, most women in all areas obtained their contraceptives through the public sector, principally government health centers and hospitals. Community-based distribution agents (CBDA) were a source of family planning methods for less than 1 percent of contraceptive users in both pilot and control areas.

Many women in both pilot and control areas do not use a family planning method, despite their approval of family planning and desire to space their next child or limit childbearing altogether. This indicates that there exists a large number of women whose need for effective and safe contraception is not currently being met.

The FPRHS showed that most women possess knowledge of means to prevent HIV/AIDS. About 90 percent of women in both pilot and control areas know that condoms can prevent HIV transmission and that limiting the number of sexual partners can also reduce the chance of getting HIV/AIDS. Despite this, just 12 percent of women in the pilot areas and 11 percent of women in control areas used a condom at last sex.

The findings of the FPRHS, while demonstrating some encouraging signs of improved reproductive health behaviours, also underscore the need for enhanced coverage of the population with cost-efficient delivery of modern contraceptive and other reproductive health services. A follow-up FPRHS planned for late 2002 is intended to evaluate how well we have taken up that challenge.

CHAPTER 1

INTRODUCTION

1.1 Geography, Population and Economy

Malawi is bordered by Tanzania to the north, Zambia on the west and Mozambique to the south and east. It is approximately 900 kilometres in length and ranges in width from 80 to 160 kilometres. It has a total area of 118,486 square kilometres, of which 94,276 are land. The remaining area consists mainly of Lake Malawi, which is about 475 kilometres long and runs down Malawi's eastern boundary with Mozambique.

Malawi has three administrative areas—the Northern Region with five districts, the Central Region with nine districts and the Southern Region with eleven districts. Each district is further subdivided into Traditional Authorities (TAs) which are presided over by Traditional Chiefs. Each TA includes a number of villages. The village is the smallest administrative unit. For census enumeration purposes, Traditional Authorities are divided into Enumeration Areas (EAs).

Malawi's climate is tropical continental with some maritime influences. Temperature and rainfall vary with proximity to Lake Malawi and altitude, which ranges from 37 metres, where the Shire River crosses into Mozambique, to 3,000 metres at the peak of Mount Mulanje.

Malawi has had population censuses since 1891. The most recent were carried out in 1987 and 1998. Other recent sources of population data in Malawi are the Malawi Demographic and Health Survey of 1992 and the Malawi Knowledge, Attitudes and Practices in Health Survey of 1996. Table 1.1 shows demographic indicators derived from the last two national censuses and the 1999/2000 World Development Report.

Table 1.1 Demographic indicators

Selected demographic indicators for Malawi, 1977-1998

Indicator	Census year		
	1977	1987	1998
Population	5547460	7,988.507	9838486
Intercensal growth rate (% p.a.)	2.9	3.2	1.9
Density (Pop./sq.km.)	59	85	105
Women of childbearing age (15-49) as percentage of total female population	45.1	44.2	Not available
Sex ratio (males/female x 100)	93	94	96
Total fertility rate (births/woman)	7.6	7.6	6.5 [b]
Crude death rate	25	14.1	23
Infant mortality rate	165	151	133 [b]
Life Expectancy (years)			
Males	39.2	41.4	43 [b]
Females	42.4	44.6	43 [b]
Contraceptive Prevalence Rate (percent currently married women using a modern method)	Not available	7[c]	14

[a] Data are from the National Statistical Office, Government of Malawi except where indicated.
[b] World Development Report, 1998-99. New York: Oxford University Press, 1998, p. 202.
[c] Based on the 1992 MDHS

Malawi has had a high rate of population growth for decades. Between 1977 and 1987, the growth rate was estimated to be 3.2 percent per year. Preliminary data from the 1998 census suggests that while growth of the population is slowing, it still hovers around 2 percent per year. High population growth in Malawi is in large part due to a continued high fertility rate. The 1992 DHS measured the Total Fertility Rate (TFR) at 6.7 children per woman. A recent estimate puts the TFR at 6.5 (World Development Report 1998-99), suggesting little recent change (Table 1.1). Rapid population growth is increasing pressure on natural resources and social services. Further growth in the population will reduce land availability per capita, and further increase the already high levels of malnutrition, poverty, and environmental degradation.

To reduce the level of poverty and to improve the quality of life, the Government of Malawi adopted a National Population Policy (NPP) in 1994. The NPP includes strategies for improving the quality of life by means of reproductive health and family planning programmes, free universal education (including gender issues) in all development programmes, as well as creating employment and small scale business opportunities. The NPP has the following goals, to be achieved by 2002: a reduction of the TFR to 5.0 children per woman, reducing infant mortality from 134 to 100 per 1000 live births, reduction of child mortality from 234 to 150 per 1000, and a decline in maternal mortality from 620 to less than 300 deaths per 100,000 live births.

1.2 Population and Family Planning Project

As part of its strategies for reducing population growth, the Ministry of Health and Population, Government of Malawi, is implementing a Population and Family Planning Project (PFPP). The objective of this project is to test the feasibility of implementing a comprehensive, district-wide community-based distribution (CBD) approach to delivery of family planning services.

Three pilot districts have been selected for testing the feasibility of this approach. Each pilot district has been paired with a control district for evaluation purposes. One pair is located in each of the three regions of Malawi. In Northern Region, the pilot district is Chitipa, while the control district is Karonga. In Central Region, the pilot is Ntchisi District and the control is Dowa District. In the South, Chiradzulu District is the pilot while Mulanje is the control. These six districts were chosen because they are among the least developed districts in Malawi. All six districts have poor access to primary health care services, including family planning.

The expected outcome of the project is an increase in the contraceptive prevalence rate (CPR) for modern family planning methods. A higher CPR will be achieved by means of 1) increased knowledge and approval of family planning, 2) increased demand for modern family planning services and 3) increased access to such services among men, women, and adolescents living in rural and under-served areas of Malawi.

The project's key performance indicators include increasing the proportion of men and women with a positive attitude toward family planning to 70 percent and a doubling of the current contraceptive prevalence rate of 14 percent to 28 percent. Since the programme is community based, it will train about 100 community-based distribution agents (CBDAs) and strive to retain at least 80 percent of them through an incentives package. Another indicator will be the average number of clients served by each CBDA by the end of the project. The project's target is an average of 200 clients per CBDA. Process indicators include the number of health workers trained to provide a wide range of family planning methods, the number of static family planning clinics with adequate contraceptives, equipment and supplies, and the number of family planning IEC messages developed and disseminated using a multi-media approach.

To assess issues related to the quality of family planning services, a Training Needs Assessment (TNA) was done alongside the FPRHS. A separate report is therefore available which shows that the quality of family planning services was below standard due to:

- inadequate staff, essential equipment and supplies, and clinic space, and
- limited access to family planning services, a narrow range of contraceptive methods, and poor infection prevention measures.

1.3 Family Planning and Reproductive Health Survey

The purpose of the PFPP in carrying out the FPRHS was to establish benchmarks for the project in three pilot districts and three adjacent control districts. The results of the baseline survey will be utilized to refine the target indicators for the project. The baseline survey will be followed at the end of the PFPP by a second survey so that changes in levels of target indicators can be assessed. The baseline and end-of-project surveys will be used along with qualitative assessments to evaluate the extent to which PFPP has achieved its objectives. Since, the PFPP project is principally a rural-based intervention, the FPRHS did not include the small part of the three pilot and three control district populations that were designated by the 1998 census as urban.

The specific objectives of the FPRHS were to collect information on the following program indicators:

Family Planning and Reproductive Health Indicators

- **Contraceptive prevalence rate (CPR).** The CPR is the proportion of all women and currently married women (15-49) who are currently using a modern method of family planning.
- **Sources of contraceptive methods.** Women were asked where they last obtained their methods of contraception so that the survey could report the percentages of contraceptive users obtaining their family planning methods from various private and public sources.
- **Approval of family planning.** Women were asked whether they approved of family planning.
- **Preferences about further childbearing.** Women were asked if they wished to have another child, space their next birth, or stop childbearing.
- **Contraceptive knowledge.** Women were questioned on their knowledge of the existence of specific contraceptive methods.
- **Knowledge of contraceptive sources.** Women were asked to name places where contraceptives can be or were obtained.
- **Knowledge of means to prevent HIV/AIDS.** Women were asked about various aspects of HIV risk, risk avoidance, and condom use.

Social and Economic Status Indicators

To provide indicators of social and economic status, information was collected on the following correlates of fertility and reproductive health behaviour:

- Female education levels
- Housing characteristics and household facilities
- Prevalence of female head of households

For many indicators, data were collected that will allow estimates to be produced for each of the three pilot districts (Chitipa, Ntchisi, and Chiradzulu) and the three control districts (Karonga. Dowa, and Mulanje). For some indicators requiring larger sample sizes, a single estimate was produced for the pilot districts taken together and a single estimate for the control districts taken together. It is expected that a similar approach will be taken for the follow-up survey conducted toward the end of the PFPP project. The FPRHS was executed in conformance with conventional procedures so as to ensure comparability with the Malawi Demographic and Health Survey (MDHS) 2000.

1.4 Organization of the Family Planning and Reproductive Health Survey

The Family Planning and Reproductive Health Survey (FPRHS) was carried out in November and December of 1999, by the Population and Family Planning Project (PFPP) of the Ministry of Health and Population (MOHP). Sampling materials were made available by the National Statistical Office (NSO). Technical assistance was provided by the Demographic and Health Research Division of Macro International, Calverton, Maryland, U. S. A. Funding for the survey was provided by PFPP under a loan agreement between the Ministry of Health and Population and the World Bank.

1.5 Sample Design

The FPRHS covered the three pilot districts and three control districts of the PFPP. A systematic sample of 25 census enumeration areas (EA) were selected as sample points in each of the six districts, totalling 150 EAs for the survey: 75 in the control districts and 75 in the pilot districts. The selection of EAs was based on the early quick counts from the 1998 national census, with the probability of EA selection being proportional to EA size.

A separate household listing operation was not conducted prior to the FPRHS fieldwork. Instead, listings were carried out before interviewing in each EA by Health Surveillance Assistants (HSAs), who had been trained as survey interviewers. In a second stage of sampling, a systematic random sample of households was "blindly" drawn from household lists by the supervisors of the interviewers. The sampling interval for the sample draw for each EA was proportional to its size based on the results from the listing. All women age 15 to 49 in the interviewed households were eligible for the survey.

1.6 Questionnaires

Two questionnaires were used in the FPRHS, a household questionnaire and a woman's questionnaire (see Appendix). Each questionnaire was composed of subsets of questions from the standard Demographic and Health Survey questionnaires. The household questionnaire included a household schedule and questions on household facilities. The woman's questionnaire contained sections on the respondent's background, reproduction, contraception, marriage and sexual activity, fertility preferences, and sexually transmitted diseases, including HIV/AIDS.

1.7 Training and Fieldwork

Training of field staff for the survey was carried out in two phases. In the first phase, which took place in Lilongwe November 15-17, 1999, district-level supervisors and some PFPP staff were trained in listing, interviewing, and supervision of interviewers. Training was done by senior survey managers from the National Statistical Office, Zomba, with help from the survey monitor from Macro International. In a second phase, district supervisors, NSO officers, and PFPP staff trained HSAs at centres located in Chiradzulu (Southern Region), Dowa (Central Region), and Karonga (Northern Region). Again training focussed on listing, questionnaires, and field procedures. The regional training also included practice listing and interviewing in neighbouring villages.

Fieldwork commenced on 26 November and was completed on 24 December, 1999. Most of the HSAs who acted as interviewers worked in the enumeration areas to which they were posted as regular employees of the MOHP. In some cases, it was necessary to utilize the services of HSAs who were from outside the EAs in which they interviewed survey respondents. The work of the HSAs was supervised by nursing staff attached to the MOHP Family Planning Programme and by the cognizant District Family Planning Coordinators.

Table 1.2 shows response rates for the FPRHS. A total of 3,450 households were selected in the sample. Of these, 3,440 were occupied as of the survey date: 1,713 in the pilot districts and 1,727 in the control districts. A total of 1,701 households were interviewed in the pilot districts and 1,694 in the control districts, for a total of 3,395 interviewed households. The overall household response rate was 99 percent: 99 percent in the pilot districts and 98 percent in the control districts. The main reason for not interviewing a household was failure to find an eligible household respondent, despite repeated visits by the interviewer.

Table 1.2 Results of the household and individual interviews

Number of households, number of interviews and response rates, by residence (pilot/control district), Malawi 1999

Result	Pilot district	Control district	Total
Household interviews			
Households sampled	1,723	1,727	3,450
Households occupied	1,713	1,727	3,440
Households interviewed	1,701	1,694	3,395
Household response rate	99.3	98.1	98.7
Individual interviews			
Number of eligible women	1,743	1,781	3,524
Number of eligible women interviewed	1,637	1,704	3,341
Eligible woman response rate	93.9	95.7	94.8

The number of eligible women (age 15-49) identified in the household schedule was 1,743 in the pilot districts and 1,781 in the control districts, for a total of 3,524 eligible respondents. Of these eligible women, 1,637 were successfully interviewed in the pilot districts (response rate of 94 percent) and 1,704 in the control districts (response rate of 96 percent). The overall response rate for eligible women was 95 percent. The main reason for not interviewing an eligible woman was failure to find her despite repeated call-backs.

All questionnaires were returned to the PFPP office for processing. Office editing, coding and data entry were carried out by staff from the Health Information System, Ministry of Health and Population under the supervision of the PFPP Monitoring and Evaluation Officer. Data entry and editing were done using the Integrated System for Survey Analysis (ISSA) developed by the Demographic and Health Surveys Programme (Macro International Inc.).

CHAPTER 2

CHARACTERISTICS OF HOUSEHOLDS AND RESPONDENTS

The purpose of this chapter is to provide a descriptive summary of selected socioeconomic characteristics of the household population and individual survey respondents. Data on age, sex, residence (pilot or control district), household composition, and facilities, and respondent background information are presented. These data can be used in two important ways. First, characteristics of the surveyed population provide a context for the interpretation of key findings on reproductive health behaviour. Second, the socioeconomic data allow for examination of the comparability of the pilot and the control districts selected by the PFPP.

2.1 Household Population

The FPRH household questionnaire provides information on the demographic and social characteristics of all usual residents of the sample households, and visitors who had spent the previous night in the household.[1]

2.1.1 Age-Sex Composition

The distribution of the FPRHS household population is shown in Table 2.1 by five-year age groups, according to sex and residence (pilot/control district). The pilot and the control age and sex distributions are also shown in the two population pyramids in Figure 2.1. The age-sex structures of the pilot and the control districts are comparable, showing the broad-based pattern that is typical of populations with high past fertility. If, as expected, fertility begins to decline the base of the pyramids should be narrowed by the birth of fewer and fewer children.

Table 2.1 Household population by age, sex, and residence

Percent distribution of the de facto household population by five-year age groups, according to sex and residence (pilot/control district), Malawi 1999

	Pilot district			Control district		
Age group	Male	Female	Both sexes	Male	Female	Both sexes
0-4	16.0	15.1	15.6	17.0	15.9	16.4
5-9	15.6	15.4	15.5	15.5	16.0	15.8
10-14	13.5	16.2	14.9	13.9	14.4	14.2
15-19	12.1	9.4	10.7	10.9	9.6	10.2
20-24	9.3	10.0	9.6	8.4	10.8	9.6
25-29	7.0	7.3	7.1	7.0	7.0	7.0
30-34	5.1	4.8	4.9	5.2	5.3	5.3
35-39	4.5	4.6	4.5	5.9	4.9	5.4
40-44	2.9	3.0	3.0	3.3	2.9	3.1
45-49	3.3	3.0	3.2	2.6	2.8	2.7
50-54	2.3	4.4	3.4	2.5	3.9	3.2
55-59	2.2	2.1	2.1	2.1	2.1	2.1
60-64	1.9	1.7	1.8	1.9	1.5	1.7
65-69	1.4	1.1	1.3	1.3	1.6	1.4
70-74	0.9	0.4	0.7	1.0	0.6	0.8
75-79	0.7	0.4	0.6	0.4	0.2	0.3
80 +	0.3	0.4	0.3	0.5	0.3	0.4
Missing/ Don't know	1.1	0.5	0.8	0.4	0.3	0.4
Total	100.0	100.0	100.0	100.0	100.0	100.0
Number	3,955	4,132	8,087	3,867	4,120	7,987

[1] A household is a group of related and unrelated person who live together in the same dwelling unit(s), who acknowledge one adult male or female as head of household, who share the same housekeeping arrangements, and are considered as one unit. A member of the household is any person who usually lives in the household and a visitor is someone who is not a usual member of the household but had slept in the household the night before the interview. The household population presented in this chapter includes, unless otherwise stated, all usual members of the household who slept in the household the night before the survey and visitors (de facto population).

Figure 2.1
Population Pyramid, Pilot Districts, Malawi 1999

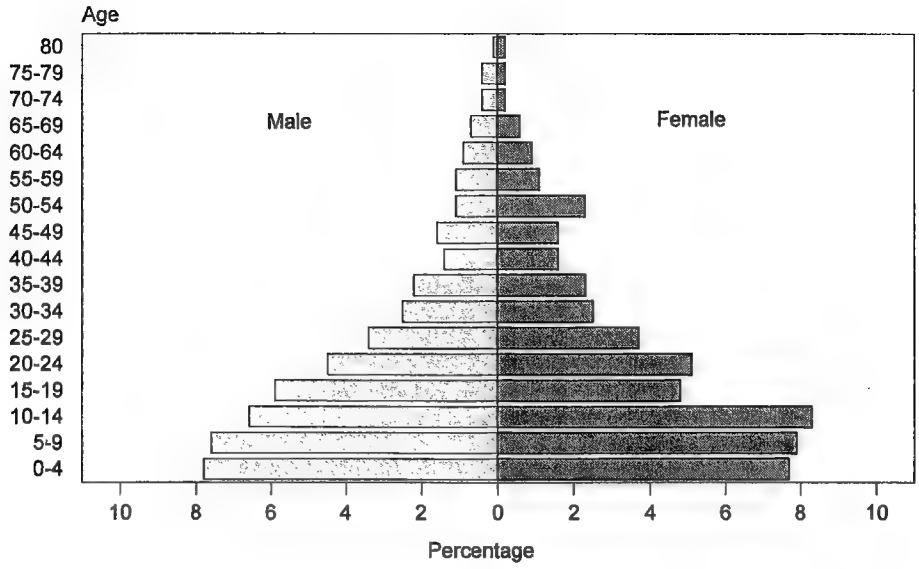


Figure 2.2
Population Pyramid, Control Districts, Malawi 1999

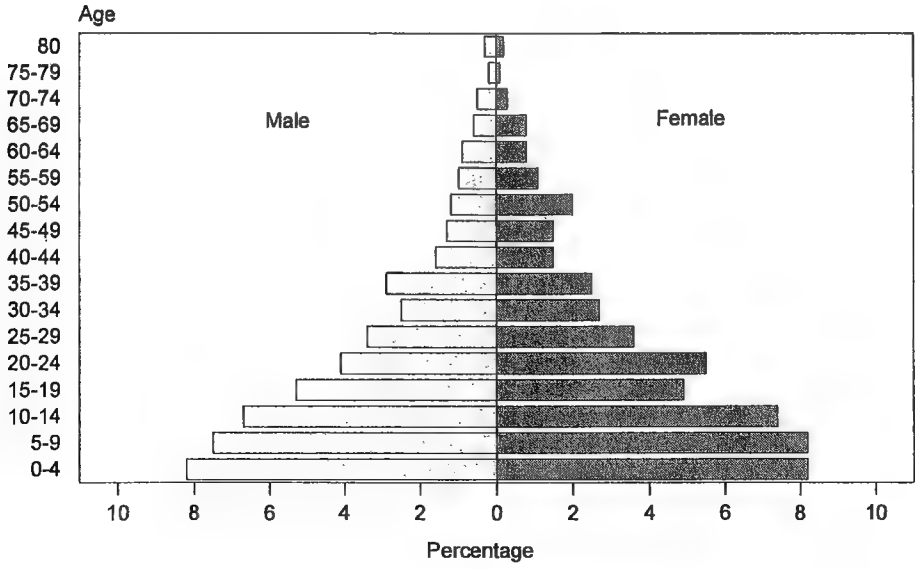


Table 2.2 Household composition

Percent distribution of households by female headship and size, Malawi 1999

Characteristic	Pilot district	Control district
Female headship (%)	24.5	24.0
No. of usual members		
1	4.1	5.4
2	11.9	12.1
3	16.7	17.9
4	17.8	16.4
5	15.4	15.2
6	12.9	11.5
7	8.6	7.7
8	5.7	6.4
9 +	6.6	7.3
Total	100.0	100.0
Mean size	4.8	4.7

2.1.2 Household Composition

Table 2.2 presents the percent distribution of households in the sample by female headship, number of usual household members, and mean household size. These characteristics are tabulated according to residence (pilot/control district). The prevalence of female headship is similar in the pilot and the control districts (25 and 24 percent). The average number of persons residing in a household in both the pilot and the control districts is about five.

2.1.3 Housing Characteristics

Information on the characteristics of the interviewed households is given in Table 2.3. The physical characteristics of housing give an indication of social and economic status and are also related to the environmental exposure of household members to disease-causing agents. In all six districts, 39 percent or more of households reported having a radio.

Generally, "piped" water and water drawn from a borehole are considered to be safer for drinking than water obtained directly from unprotected wells and surface sources like rivers and lakes. Piped water supplies were most prevalent in Mulanje (33 percent) and least prevalent in the Central Region districts of Dowa and Ntchisi (2 percent). Use of water from a borehole (protected well) varied from 68 percent in Chiradzulu to 25 percent in Dowa.

The proximity of a household to a water source is an important factor in determining patterns of water use. The FPRHS asked respondents to report how long it takes to reach the principal water source and return. In both the pilot and the control districts, 28 percent of households reported that it takes less than 15 minutes to make this trip, although households in Karonga and Ntchisi have a slightly harder time of it.

The majority of households use pit toilets/latrines, although around one-quarter of households in Dowa and Karonga reported no use of a latrine or toilet. Most households in all of the studied districts have unfinished floors (earth or sand).

In general, the pilot districts are very similar to the control districts in terms of household characteristics and amenities. This suggests populations of comparable socioeconomic development. As an exception, the pilot districts tend to have less access to a piped water supply, but more access to latrine/toilet facilities. These differences however are small.

2.2 Characteristics of Respondents

Background characteristics of the 3,341 women age 15-49 who were interviewed in the survey appear in Table 2.4. Chitipa and Karonga districts have slightly larger proportions of women in the youngest age group (15-19) than the other districts. Generally, however, the age structure of respondents is comparable across districts.

Table 2.3 Housing characteristics

Percent distribution of households by housing characteristics and amenities, according to district and residence (pilot/control district), Malawi 1999

Characteristic	District						Residence	
	Chitipa (P)	Karonga (C)	Ntchisi (P)	Dowa (C)	Chiradzulu (P)	Mulanje (C)	Pilot district	Control district
Radio								
Have radio	40.2	41.0	42.0	46.0	39.2	43.2	40.5	43.4
No radio	57.5	58.5	56.4	53.6	58.5	56.8	57.5	56.3
Missing	2.3	0.5	1.6	0.4	2.3	0.0	2.1	0.3
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Source of drinking water								
Piped water	15.3	14.5	2.3	2.3	7.1	32.5	8.3	16.4
Bore hole/protected well	28.4	53.4	36.3	24.5	68.4	27.0	44.3	35.0
Unprotected well	18.5	17.0	45.9	51.1	15.5	13.8	26.6	27.3
Surface water	37.8	15.2	15.5	21.3	9.0	26.8	20.9	21.1
Other	0.0	0.0	0.0	0.7	0.0	0.0	0.0	0.2
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Time to water source and back								
Less than 15 minutes (%)	32.9	24.9	20.8	30.7	29.5	29.6	27.8	28.4
Sanitation facilities								
Flush toilet	0.5	0.2	0.4	0.2	0.9	0.2	0.6	0.2
Pit toilet/latrine	92.7	74.9	79.2	72.1	90.8	89.3	87.6	78.7
No facility, bush, field	5.1	23.9	18.7	27.2	5.8	10.5	9.8	20.6
Missing	1.7	1.1	1.8	0.5	2.5	0.0	2.0	0.5
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Flooring								
Earth and other unfinished	93.0	93.2	95.8	96.1	86.6	84.3	91.8	91.2
Cement and other finished	5.1	6.4	3.0	3.5	11.1	15.7	6.4	8.5
Missing	1.9	0.5	1.2	0.4	2.3	0.0	1.8	0.3
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Number of households	574	566	562	567	566	560	1,702	1,693

The proportion of women who reported that they were currently married ranges from 71 percent in Karonga to 34 percent in Chiradzulu. Sixty percent of women living in the control districts were reported as married, compared with only 49 percent in the pilot districts. However, the proportion of women who reported either that they were married or in a consensual union was about the same, 76 percent in the pilot districts and 75 percent in the control districts. In the rest of the report, the term "currently married" includes both formal and informal (consensual) unions.

A much smaller percentage of women in the Northern Region's Chitipa and Karonga districts reported that they had no formal education than in the other districts. However, when the pilot and the control districts are viewed as groups, the proportion of women reporting that they had no formal education is virtually the same (25 percent for the pilot districts and 26 percent for the control districts). Very few respondents had any post-secondary education; in Chitipa, Ntchisi, Dowa, and Mulanje districts, no women reported having any post-secondary education.

Table 2.4 Background characteristics of women

Percent distribution of women by age, and percentage with selected background characteristics, according to residence (pilot/control district), Malawi 1999

Characteristic	District						Residence	
	Chitipa (P)	Karonga (C)	Ntchisi (P)	Dowa (C)	Chiradzulu (P)	Mulanje (C)	Pilot district	Control district
Age								
15-19	24.2	23.4	19.0	20.4	17.2	20.0	20.5	21.3
20-24	23.5	26.5	24.5	22.0	23.0	24.7	23.6	24.4
25-29	17.7	15.9	17.0	19.1	18.6	15.6	17.8	16.8
30-34	11.1	11.1	10.7	14.3	13.0	11.3	11.5	12.2
35-39	10.8	10.8	12.5	11.4	11.6	13.2	11.5	11.8
40-44	4.6	6.7	7.9	5.7	10.0	7.5	7.3	6.6
45-49	8.1	5.8	8.5	7.0	6.6	7.7	7.8	6.8
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Marital status								
Never married	16.0	14.3	14.8	14.8	14.2	12.5	15.1	13.9
Currently married	61.0	71.3	49.0	60.8	33.8	45.8	49.0	59.5
Currently in consensual union	17.3	5.1	30.4	16.5	34.4	24.5	26.6	15.2
Widowed	1.9	2.0	1.2	2.1	4.8	3.8	2.6	2.6
Divorced	1.0	2.9	1.6	1.6	5.8	5.9	2.6	3.5
Separated	1.7	2.7	2.0	2.5	3.2	4.7	2.3	3.3
Education								
No education	13.6	12.8	34.0	33.6	29.0	31.8	24.6	25.9
Primary	75.9	76.5	60.9	59.9	60.8	62.4	66.6	66.4
Secondary	10.5	10.6	5.1	6.4	10.0	5.7	8.7	7.6
Post-secondary	0.0	0.2	0.0	0.0	0.2	0.0	0.1	0.1
Number of women	631	586	506	559	500	559	1,637	1,704

CHAPTER 3

FERTILITY REGULATION

This chapter presents the FPRHS results regarding various aspects of contraceptive knowledge, attitudes, and behaviour. The chapter summarizes the following key indicators of the PFPP: prevalence of knowledge of contraceptive methods, ever use of contraceptive methods, current use of contraceptive methods, sources of supply for current users, contact of nonusers with family planning providers, and attitudes of women toward family planning.

3.1 Knowledge of Contraceptive Methods

One of the objectives of the FPRHS was to collect information on the extent of knowledge of family planning methods among women age 15-49. Individuals who are adequately informed about their options regarding methods of contraception are better able to develop an approach to fertility that is in keeping with the best interests of their families. Information on knowledge of contraception was collected by asking respondents to name the ways by which a couple can delay or avoid pregnancy. If a respondent failed to mention a particular method spontaneously, the interviewer described the method and asked if she recognized it.

Table 3.1 and Figure 3.1 show the percent distribution of all women, currently married women, and sexually active unmarried women by knowledge of contraceptive methods. Knowledge of family planning methods is quite high with 90 percent of respondents in the pilot districts and 93 percent in the control districts knowing at least one method of family planning.

In the pilot districts, 89 percent of respondents were able to name at least one modern method of contraception, compared with 93 percent in the control districts. High levels of knowledge of a modern method was also reported for currently married women (92 percent in the pilot districts and 95 percent in the control districts), sexually active unmarried women (89 percent in the pilot districts and 88 percent in the control districts), and unmarried women who were not sexually active (91 and 93 percent in the pilot and the control districts, respectively).

Among married and unmarried women, for both the pilot and the control districts, the pill, injectables and the male condom were the most widely known methods of family planning. More than 80 percent of women in the pilot and the control districts have heard of injectables and the pill, while knowledge of the male condom is slightly lower. Among all women, married women, unmarried sexually active women, and unmarried women who were not sexually active, knowledge of female sterilisation and implants is consistently higher in the control districts than in the pilot districts.

Fifty-four percent of women in the pilot districts know a traditional method of contraception, while 66 percent of women in the control districts know such a method.

Table 3.2 shows knowledge of contraceptive methods among currently married women by background characteristics. In both the pilot and the control districts, women age 20-44 (women in their most active child-bearing years or having recently passed through these years) tend to be more familiar with at least one method of family planning, or at least one modern method of family planning than women age 15-19 and 45-49.

A woman's knowledge of family planning methods increases with increasing level of education in both the pilot and the control districts. Within education categories, there are no large differences in knowledge of family planning between the pilot and the control districts, although familiarity with family planning tends to be slightly higher in the control districts than in the pilot districts.

Table 3.1 Knowledge of contraceptive methods

Percentage of all women, currently married women, sexually active unmarried women, and sexually inactive unmarried women, who know specific contraceptive methods, by residence (pilot/control district), Malawi 1999

Method	All women		Currently married women		Unmarried women: Sexually active		Unmarried women: Not sexually active	
	Pilot	Control	Pilot	Control	Pilot	Control	Pilot	Control
Any method	90.0	93.3	92.9	95.8	88.7	88.2	91.0	93.1
Any modern method	88.9	92.5	91.5	94.9	88.7	88.2	91.0	93.1
Pill	82.2	86.4	86.0	89.8	69.4	83.8	84.4	83.3
IUD	47.7	54.2	51.3	57.9	32.3	45.6	48.1	52.2
Injectables	83.0	86.3	87.5	90.5	72.6	79.4	80.7	82.6
Diaphragm/cervical cap	12.5	19.0	14.1	20.3	8.1	13.2	9.9	19.6
Foam/jelly	14.0	22.7	15.6	24.2	6.5	19.1	11.3	22.8
Female condom	31.0	36.0	34.0	37.9	21.0	33.8	26.9	35.1
Male condom	77.9	82.2	80.8	84.4	80.6	83.8	76.4	83.0
Female sterilisation	58.3	71.0	62.1	74.9	45.2	66.2	56.1	67.4
Male sterilisation	38.5	42.0	42.2	45.2	21.0	39.7	35.8	37.3
Implants	24.3	35.3	26.1	38.4	12.9	26.5	25.0	32.2
Emergency contraception	13.0	21.9	12.9	23.3	11.3	26.5	17.5	20.7
Lactational Amenorrhoea Method (LAM)	26.8	37.9	28.8	39.7	19.4	33.8	23.6	39.1
Any traditional method	53.5	65.5	59.1	69.4	41.9	54.4	43.4	63.8
Periodic abstinence	24.5	40.1	26.6	41.9	21.0	30.9	20.8	42.8
Withdrawal	40.0	43.0	44.2	46.7	33.9	26.5	30.7	42.0
Other	19.8	29.8	22.7	31.4	8.1	29.4	16.0	28.3
Mean number of modern methods known	4.8	5.6	5.1	5.9	3.8	5.2	4.7	5.4
Number of women	1,637	1,704	1,237	1,273	62	68	212	276

Figure 3.1
Percentage of Currently Married Women Reporting Knowledge of Various Contraceptive Methods by Residence (Pilot/Control district)

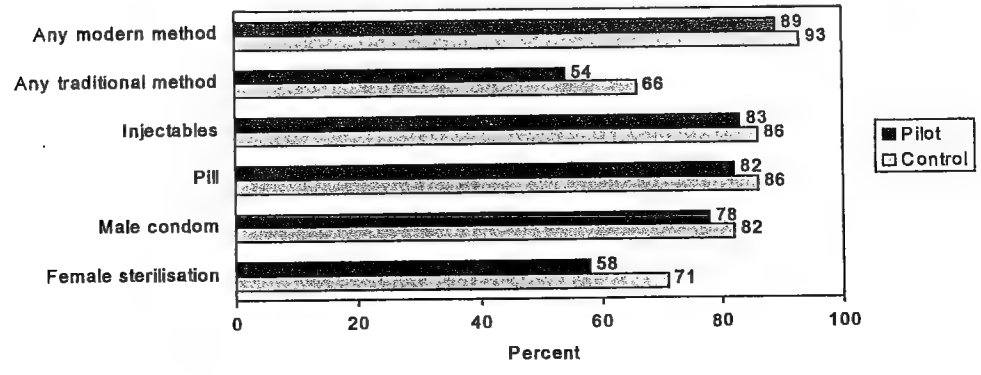


Table 3.2 Knowledge of contraceptive methods by background characteristics

Percentage of currently married women who know at least one contraceptive method and who know at least one modern contraceptive method, by age, education, and residence (pilot/control district), Malawi 1999

Background characteristic	Knows any method		Knows any modern method		Number of women	
	Pilot district	Control district	Pilot district	Control district	Pilot district	Control district
Age						
15-19	83.1	90.4	81.5	89.0	130	146
20-24	92.9	97.9	91.9	96.5	322	341
25-29	97.7	96.5	96.9	96.5	257	259
30-34	94.4	96.6	93.8	96.6	160	177
35-39	95.8	97.6	92.9	97.6	168	168
40-44	91.7	95.8	89.6	92.7	96	96
45-49	87.5	89.5	85.6	87.2	104	86
Education						
No education	89.2	92.9	86.9	91.8	344	380
Primary	93.8	96.9	92.8	95.9	818	834
Secondary+	100.0	100.0	98.7	100.0	75	59
Total	92.9	95.8	91.5	94.9	1,237	1,273

3.2 Ever Use of Contraception

All women interviewed in the FPRHS who said that they had heard of at least one family planning method were asked if they had ever used a method for delaying or preventing pregnancy. Table 3.3 shows the proportion of women who have ever used a contraceptive method by method and residence (pilot/control district). Among currently married women, the level of ever use in the pilot districts (53 percent) is similar to that in the control districts (57 percent). As expected, ever use of family planning is lower among unmarried women than married women except for the use of condoms, the most commonly used method among unmarried women.

Ever use of any modern method is similar in both the pilot and the control districts. For currently married women, 40 percent reported ever use in the pilot districts compared with 43 percent in the control districts.

Among all women the most commonly reported ever-used modern method was injectables, followed by the male condom and the pill. Ever use of injectables ranged from 21 to 27 percent among all women and married women in the pilot and the control districts, while only 10 percent (pilot districts) and 12 percent (control districts) of sexually active unmarried women reported having ever used injectables.

Ever use of condoms is less related to marital status than other methods. In the pilot districts, condom use is 15 percent for both currently married and sexually active unmarried women; in the control districts 15 percent of married and 19 percent of unmarried women have used a condom in the past.

Table 3.3 Ever use of contraception among women

Percentage of all women, currently married women, and sexually active unmarried women who have ever used contraception, by method and residence (pilot/control district), Malawi 1999

		Modern method												Traditional method				
Residence	**Any method**	**Any modern method**	Pill	IUD	Inject-ables	Dia-phragm	Foam/ Jelly	Female condom	Male condom	Female sterili-sation	Male sterili-sation	Im-plants	Emergency contra-ception	LAM	**Any trad. method**	Periodic absti-nence	With-draw-al	Other trad. methods	Number of women
ALL WOMEN																			
Pilot district	47.0	35.7	10.2	0.8	21.4	0.2	0.2	0.4	13.9	2.2	0.5	0.4	0.9	4.2	19.9	4.0	15.1	5.7	1,637
Control district	50.6	38.3	11.0	0.9	23.1	0.4	1.1	0.5	13.4	3.7	0.6	0.3	1.4	6.8	25.1	10.1	15.5	7.5	1,704
CURRENTLY MARRIED WOMEN																			
Pilot district	53.3	39.9	11.3	1.0	24.8	0.3	0.3	0.3	14.6	2.7	0.7	0.6	1.0	5.4	23.5	4.4	18.4	6.6	1,237
Control district	57.3	43.3	12.5	1.1	27.1	0.4	1.1	0.5	14.4	4.5	0.7	0.4	1.5	7.4	29.0	11.5	18.8	8.1	1,273
SEXUALLY ACTIVE UNMARRIED WOMEN																			
Pilot district	33.9	24.2	6.5	0.0	9.7	0.0	0.0	1.6	14.5	0.0	0.0	0.0	0.0	1.6	14.5	6.5	9.7	3.2	62
Control district	33.8	32.4	8.8	1.5	11.8	0.0	1.5	1.5	19.1	0.0	0.0	0.0	1.5	2.9	10.3	4.4	0.0	7.4	68

LAM = lactational amenorrhoea method

Reported ever use of the pill ranges from 10 to 13 percent among all women and married women in the pilot and the control districts. For sexually active unmarried women, reported ever use of the pill was 7 percent in the pilot districts compared with 9 percent in the control districts.

Ever use of any traditional method was 25 and 30 percent for married women in the pilot and the control districts, respectively, while comparable figures for unmarried women were 16 and 12 percent.

3.3 Current Use of Contraceptive Methods

The contraceptive prevalence rate (CPR) is the most widely used measure of contraceptive use and is a reliable indicator of the success of family planning programmes. The most commonly reported CPR is the percentage of currently married women age 15-49 who are using a modern method of contraception at the time of the survey. The use of currently married women (and not all women) as a base for the contraceptive prevalence rate is important when the CPR, as a single measure, is used for programme evaluation (i.e., trend assessment). This is because changing contraceptive use patterns combined with changing age patterns in marriage can complicate evaluation of an "all women" CPR over time.

Table 3.4 and Figure 3.2 show that the CPR (any modern method) for currently married women is 24 percent in the pilot districts and 25 percent in the control districts. If all methods (including traditional methods) are considered, the CPR jumps to 32 percent in the pilot and 34 percent in the control districts. Use of traditional methods is 9 percent in the pilot districts and 10 percent in the control districts. The most commonly used traditional method is withdrawal, and the highest levels of withdrawal occur in Chitipa and Karonga districts in the Northern Region.

Looking at use of specific modern methods, injectables are by far the most commonly used method: 14 percent of currently married women in both the pilot and the control districts use this method. In the pilot districts, injectables are followed by the pill (4 percent), condoms (4 percent), and female sterilisation (3 percent). In the control districts, pill use is slightly lower (2 percent), condom use is the same (4 percent), and female sterilisation is slightly higher (4 percent). All other modern methods are used by very few women in both the pilot and the control districts.

As expected, the CPR (modern methods) for unmarried sexually active women is much lower than for married women: 13 percent in the pilot districts and 19 percent in the control districts. The male condom is the only method that is used by a greater proportion of unmarried women than married women. Presumably, this is related to the need felt by unmarried women for a temporary method that protects against *both* pregnancy *and* disease transmission.

Table 3.4 indicates there is substantial variation among the 6 districts in the level of contraceptive use and method mix. The CPR (modern methods, currently married women) ranges from 18 percent in Karonga to 30 percent in Dowa. Dowa's high CPR is largely due to the high level of use of injectables (20 percent). Compare this to just 4 percent use of injectables in Karonga district. Again, it should be mentioned that the all-methods CPR is very high in Chitipa and Karonga, but this is largely the result of very high levels of use of withdrawal as a method of family planning. In Karonga and Chitipa, condom use is much higher than in other districts and, in the case of Karonga, accounts for 56 percent of all modern method use. In the 4 districts of the Central and Southern Regions, use of injectables very much drives the overall level of use of modern methods, although in Mulanje nearly one-quarter of users of modern methods reported that they were sterilised.

In Table 3.4, for the category sexually active unmarried women there were fewer than 50 respondents in each district, so the CPR was not reported by district.

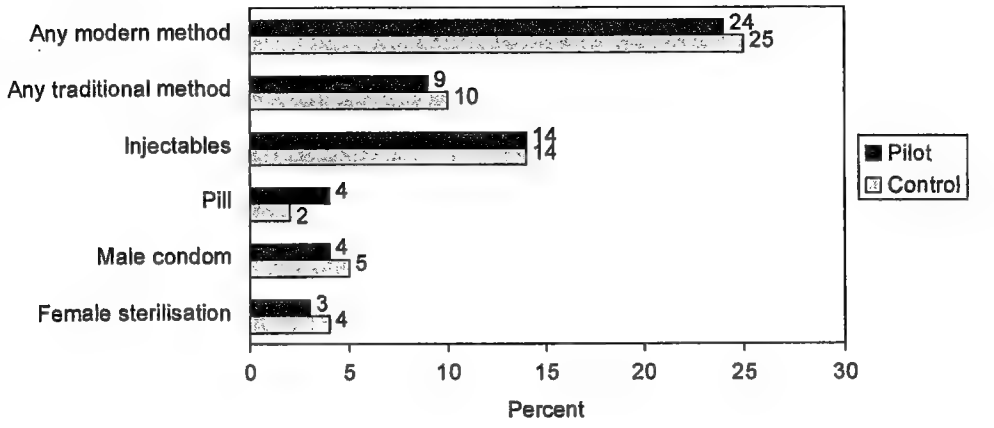
Table 3.4 Current use of contraception

Percent distribution of all women, currently married women, and sexually active unmarried women who are currently using a contraceptive method by method, according to district and residence (pilot/control district), Malawi 1999

District/ Residence	Any method	Modern method: Any modern method	Pill	IUD	Injectables	Diaphragm/ foam/ jelly	Condom	Female sterilisation	Male sterilisation	Implants	LAM	Traditional method: Any trad. method	Periodic abstinence	Withdrawal	Other trad. methods	Total	Number of women
ALL WOMEN																	
District																	
Chitipa (P)	38.2	23.0	5.2	0.3	8.9	0.0	7.4	2.1	0.2	0.2	1.3	16.0	1.3	14.7	0.8	100.0	631
Karonga (C)	36.5	16.7	2.4	0.2	3.1	0.3	9.7	2.6	0.0	0.0	0.3	21.7	2.7	17.6	2.4	100.0	586
Ntchisi (P)	20.6	19.4	2.4	0.0	14.0	0.0	1.6	1.8	0.0	0.0	0.2	1.0	0.0	0.6	0.4	100.0	506
Dowa (C)	27.2	25.2	1.8	0.0	17.5	0.0	2.7	3.4	0.0	0.0	0.4	1.6	0.9	0.0	0.9	100.0	559
Chiradzulu (P)	20.0	16.8	1.2	0.0	11.8	0.0	1.2	2.8	0.0	0.0	0.2	3.0	1.0	1.6	0.4	100.0	500
Mulanje (C)	24.0	22.2	1.6	0.2	15.0	0.0	0.7	4.5	0.0	0.2	0.4	1.6	0.5	0.0	1.1	100.0	559
Residence																	
Pilot district	27.2	20.0	3.1	0.1	11.4	0.0	3.7	2.2	0.1	0.1	0.6	7.4	0.8	6.4	0.5	100.0	1,637
Control district	29.3	21.3	1.9	0.1	11.7	0.1	4.5	3.5	0.0	0.1	0.4	8.5	1.4	6.0	1.5	100.0	1,704
CURRENTLY MARRIED WOMEN																	
District																	
Chitipa (P)	44.9	26.3	6.1	0.4	10.3	0.0	8.1	2.4	0.2	0.2	1.6	19.6	1.4	18.2	1.0	100.0	494
Karonga (C)	41.3	18.3	2.5	0.2	3.8	0.4	10.3	2.7	0.0	0.0	0.4	24.8	3.1	21.7	1.3	100.0	448
Ntchisi (P)	24.1	22.6	2.2	0.0	17.4	0.0	1.0	2.2	0.0	0.0	0.2	1.2	0.0	0.7	0.5	100.0	402
Dowa (C)	32.4	29.9	1.9	0.0	20.8	0.0	2.8	4.4	0.0	0.0	0.5	2.1	1.2	0.0	1.2	100.0	432
Chiradzulu (P)	23.8	20.5	1.5	0.0	14.7	0.0	1.2	3.5	0.0	0.0	0.3	2.9	0.9	1.5	0.6	100.0	341
Mulanje (C)	28.0	26.2	2.0	0.3	17.8	0.0	0.0	5.9	0.0	0.3	0.5	1.5	0.8	0.0	0.8	100.0	393
Residence																	
Pilot district	32.3	23.5	3.6	0.2	13.8	0.0	3.9	2.7	0.1	0.1	0.8	9.1	0.8	7.9	0.7	100.0	1,237
Control district	34.2	24.7	2.1	0.2	13.9	0.2	4.6	4.2	0.0	0.1	0.5	9.9	1.7	7.6	1.1	100.0	1,273
SEXUALLY ACTIVE UNMARRIED WOMEN																	
Pilot district	19.4	12.9	1.6	0.0	6.5	0.0	6.5	0.0	0.0	0.0	0.0	6.5	3.2	3.2	0.0	100.0	62
Control district	20.6	19.1	4.4	0.0	8.8	0.0	8.8	0.0	0.0	0.0	0.0	2.9	1.5	0.0	1.5	100.0	68

LAM = lactational amenorrhoea method

Figure 3.2
Percentage of Currently Married Women Using Contraceptive Methods by Residence (pilot/control district)



3.4 Number of Children at First Use of Contraception

Family planning can be used to limit family size or for spacing or delaying births. Couples who want large families will tend not to use contraception until late in their reproductive lives, at which time they may decide to use it to stop any additional childbearing. On the other hand, couples who use contraception to increase birth intervals will tend to begin using it earlier for purposes of delaying pregnancy. To obtain information on the relationship between first use of contraception and number of children, the FPRHS asked women how many children they had when they first used family planning.

Table 3.5 shows the distribution of ever-married women by number of children at the time of first use of contraception and residence (pilot/control district), according to age. Younger cohorts of women reported first use at lower parity than older cohorts of women. For example, in the pilot districts, about 11 percent of women age 15-19, 6 percent of women age 20-24 and less than 3 percent of women age 25 and older used a contraceptive method before having a child. A similar though slightly less pronounced pattern is observed in the control districts. This finding is consistent with an increasing tendency among women to adopt contraception for child-spacing purposes (i.e., at younger ages).

Table 3.5 Number of children at first use of contraception

Percent distribution of ever-married women by number of living children at the time of first use of contraception and residence (pilot/control district), and median number of children at first use, according to current age, Malawi 1999

Current age	Never used contra-ception	Number of living children at time of first use of contraception						Total	Median number of children at first use	Number of women
		0	1	2	3	4+	Missing			
PILOT DISTRICT										
15-19	70.0	11.3	18.0	0.7	0.0	0.0	0.0	100.0	1.0	150
20-24	45.6	5.9	30.6	10.5	3.7	2.3	1.4	100.0	1.0	353
25-29	42.1	1.8	21.8	13.9	12.5	7.1	0.7	100.0	2.0	280
30-34	40.9	0.5	15.6	12.4	10.2	19.9	0.5	100.0	3.0	186
35-39	44.7	0.6	8.9	10.6	7.8	26.8	0.6	100.0	3.0	179
40-44	53.0	2.6	7.7	6.0	4.3	25.6	0.9	100.0	4.0	117
45-49	47.2	0.8	13.6	10.4	6.4	20.0	1.6	100.0	3.0	125
CONTROL DISTRICT										
15-19	68.4	9.9	19.9	1.8	0.0	0.0	0.0	100.0	1.0	171
20-24	42.3	4.4	37.1	13.1	1.6	1.3	0.3	100.0	1.0	383
25-29	38.0	2.8	20.8	22.2	11.3	4.2	0.7	100.0	2.0	284
30-34	41.1	1.9	11.6	5.8	10.6	29.0	0.0	100.0	3.0	207
35-39	39.9	1.5	13.6	8.6	10.1	26.3	0.0	100.0	3.0	198
40-44	44.1	3.6	9.0	11.7	2.7	27.9	0.9	100.0	4.0	111
45-49	43.4	3.5	8.8	7.1	4.4	32.7	0.0	100.0	4.0	113

3.5 Source of Family Planning Methods

Table 3.6 and Figure 3.3 show the proportion of respondents who reported obtaining specific modern methods of contraception from various sources. The majority of respondents obtained their last modern contraceptive method from government (public) institutions—84 percent of users in the pilot districts, 73 percent in the control districts. Government health centres are the most commonly used single source of modern contraceptive methods, accounting for about one-half of reported sources in both the pilot and the control districts. Private medical sources accounted for 13 percent of use of modern methods in the pilot districts and 20 percent in the control districts. Reliance on public sector sources for modern contraceptive methods thus appears to be greater in the pilot districts than in the control districts.

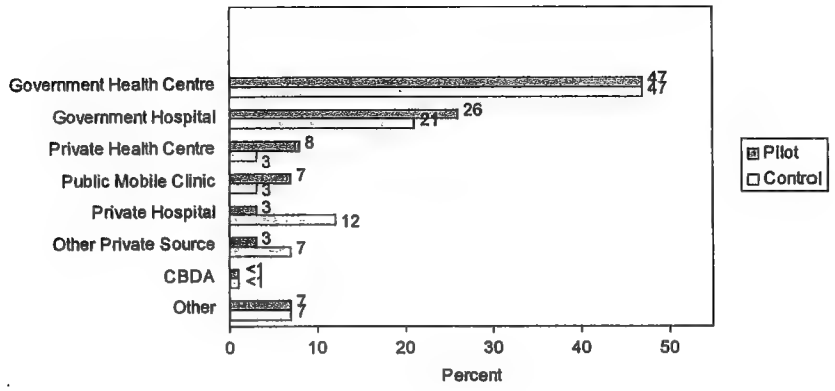
In both the pilot and the control districts, less than 1 percent of respondents reported obtaining their last modern contraceptive method from a CBDA, indicating that CBDAs play a negligible role in supplying contraceptives to women in the PFPP study area at the project's inception. This finding underscores the need for PFPP's CBDA intervention in the project districts. Further, the finding validates the baseline nature of the survey, and (should the same data be collected in the follow-up survey) will facilitate interpretation of changes in the CPR.

Table 3.6 Source of supply among current users

Percent distribution of current users of modern contraceptive methods by most recent source of supply, according to method and residence (pilot/control district), Malawi 1999

Source of supply	Pill	Inject-ables	Male condom	Female sterili-sation	Other	All modern methods
PILOT DISTRICT						
Public sector	**92.2**	**88.0**	**76.3**	**66.7**	**100.0**	**84.4**
Government hospital	27.5	21.2	13.6	63.9	100.0	26.3
Government health centre	43.1	57.1	47.5	2.8	0.0	46.7
Public dispensary/maternity clinic	2.0	3.3	0.0	0.0	0.0	2.1
Public mobile clinic	15.7	6.0	5.1	0.0	0.0	6.6
CBDA	2.0	0.0	3.4	0.0	0.0	0.9
Other public sources	2.0	0.5	6.8	0.0	0.0	1.8
Private medical	**7.8**	**10.9**	**11.9**	**33.3**	**0.0**	**12.9**
Private hospital	0.0	1.6	0.0	22.2	0.0	3.3
Private health centre	7.8	7.6	6.8	8.3	0.0	7.5
Private dispensary/ maternity clinic	0.0	1.1	0.0	0.0	0.0	0.6
Private mobile clinic	0.0	0.5	3.4	2.8	0.0	1.2
Private doctor	0.0	0.0	1.7	0.0	0.0	0.3
Other private medical	0.0	0.0	0.0	0.0	0.0	0.0
Other private sources	**0.0**	**1.1**	**11.9**	**0.0**	**0.0**	**2.7**
Shop/Pharmacy	0.0	0.5	11.9	0.0	0.0	2.4
Friend/relative	0.0	0.0	0.0	0.0	0.0	0.0
Other	0.0	0.5	0.0	0.0	0.0	0.3
Total	100.0	100.0	100.0	100.0	100.0	100.0
Number	51	184	59	36	4.0	334
CONTROL DISTRICT						
Public sector	**81.8**	**86.0**	**70.7**	**32.8**	**20.0**	**73.3**
Government hospital	9.1	24.5	9.3	32.8	0.0	21.0
Government health centre	60.6	56.5	56.0	0.0	20.0	47.4
Public dispensary/maternity clinic	3.0	1.0	2.7	0.0	0.0	1.3
Public mobile clinic	3.0	4.0	2.7	0.0	0.0	3.0
CBDA	6.1	0.0	0.0	0.0	0.0	0.5
Other public sources	0.0	0.0	0.0	0.0	0.0	0.0
Private medical	**15.2**	**14.0**	**2.7**	**65.5**	**40.0**	**20.2**
Private hospital	6.1	4.5	1.3	55.2	20.0	12.1
Private health centre	0.0	4.5	0.0	3.4	20.0	3.2
Private dispensary/ maternity clinic	3.0	1.0	0.0	0.0	0.0	0.8
Private mobile clinic	0.0	1.0	0.0	0.0	0.0	0.5
Private doctor	0.0	0.0	0.0	1.7	0.0	0.3
Other private medical	6.1	3.0	1.3	5.2	0.0	3.2
Other private sources	**3.0**	**0.0**	**26.7**	**1.7**	**40.0**	**6.5**
Shop/Pharmacy	3.0	0.0	26.7	0.0	0.0	5.7
Friend/relative	0.0	0.0	0.0	0.0	40.0	0.5
Other	0.0	0.0	0.0	1.7	0.0	0.3
Total	100.0	100.0	100.0	100.0	100.0	100.0

Figure 3.3
Distribution of Current Users by Source of Supply for Modern Contraceptive Methods, According to Residence (pilot/control district)



Malawi 1999

3.6 Contact of Nonusers of Family Planning with Family Planning Providers

In the FPRHS women were asked whether they had been visited by a family planning worker in the 12 months prior to the interview. They were also asked if they had visited a health centre during the previous 12 months. Respondents who had visited a health centre were also asked whether staff at the centre had discussed family planning methods with them. This information is important for the PFPP, which is seeking to increase the prevalence of contacts between CBDAs and other family planning workers and women aged 15-49, especially those who do not use contraception. Another goal of the project is to train staff in health centres to give family planning advice to all women aged 15-49, especially nonusers of family planning.

Table 3.7 shows that the pilot and the control districts are remarkably similar in terms of contact of nonusers of family planning with family planning providers. Sixty-seven percent of nonusers in both the pilot and the control districts reported that they had not been visited by a family planning worker *and* had not received family planning counselling from the staff of a health facility. Of those women who did receive some contact with a family planning provider, most received that contact through attendance at a health facility.

The percentage of women contacted in their community by a family planning worker can be obtained by summing the first three columns of Table 3.7. This shows that just 17 percent of nonusers in the pilot districts and 19 percent of nonusers in the control districts had received a visit by a family planning worker.

In the pilot districts, 20 percent of the nonusers were not visited by a family planning worker and, although they did visit a health facility, family planning was not discussed. For the control districts, the comparable figure is 23 percent. These cases may be viewed as "missed opportunities".

Table 3.7 Contact of nonusers with family planning providers

Percent distribution of women who were not using contraception by whether or not they were visited by a family planning (FP) worker or spoke with a health facility staff member about family planning during the 12 months prior to the interview, according to background characteristics and residence (pilot/control district), Malawi 1999

Background characteristic	Visited by a family planning worker?								Neither visited by FP worker, nor discussed FP at health facility	Number of women
	Yes			No			Missing	Total		
	Attended and discussed family planning	Attended, did not discuss family planning	Did not attend	Attended and discussed family planning	Attended, did not discuss family planning	Did not attend				
PILOT DISTRICT										
Age										
15-19	5.8	1.0	7.1	4.4	19.0	61.4	1.4	100.0	80.3	295
20-24	7.2	4.3	4.7	23.4	23.4	36.2	0.9	100.0	59.6	235
25-29	7.9	5.5	6.1	26.1	18.8	35.2	0.6	100.0	53.9	165
30-34	11.2	0.9	7.5	14.0	28.0	37.4	0.9	100.0	65.4	107
35-39	11.9	0.8	8.5	14.4	22.9	39.8	1.7	100.0	62.7	118
40-44	3.4	4.5	7.9	23.6	14.6	46.1	0.0	100.0	60.7	89
45-49	4.5	3.4	3.4	12.5	13.6	60.2	2.3	100.0	73.9	88
Education										
No education	6.1	3.7	4.7	18.0	19.3	47.1	1.0	100.0	66.4	295
Primary	7.6	2.6	6.8	16.3	20.4	45.2	1.1	100.0	65.6	701
Secondary+	8.9	2.0	7.9	7.9	23.8	48.5	1.0	100.0	72.3	101
Total	7.3	2.8	6.4	16.0	20.4	46.0	1.1	100.0	66.5	1,097
CONTROL DISTRICT										
Age										
15-19	3.3	0.7	7.6	7.6	20.9	59.6	0.3	100.0	80.5	302
20-24	10.6	7.7	4.9	19.9	24.0	32.1	0.8	100.0	56.1	246
25-29	14.9	5.8	4.5	13.6	23.4	37.7	0.0	100.0	61.0	154
30-34	13.8	1.6	5.7	17.1	20.3	41.5	0.0	100.0	61.8	123
35-39	10.2	4.2	6.8	17.8	22.0	37.3	1.7	100.0	59.3	118
40-44	10.4	3.9	3.9	9.1	22.1	50.6	0.0	100.0	72.7	77
45-49	3.8	3.8	3.8	11.5	37.2	39.7	0.0	100.0	76.9	78
Education										
No education	5.5	3.8	6.2	13.7	21.9	48.6	0.3	100.0	70.5	292
Primary	10.4	3.6	5.5	12.7	23.7	43.6	0.4	100.0	67.3	722
Secondary+	9.5	7.1	6.0	22.6	23.8	29.8	1.2	100.0	53.6	84
Total	9.0	3.9	5.7	13.8	23.2	43.9	0.5	100.0	67.1	1,098

The probability of being exposed to family planning information is related to age and education. Table 3.7 shows that the youngest and oldest nonusers are least likely to have received counseling. Women in their peak childbearing years or just past them are most likely to have received family planning advice. This inverted U-shaped pattern is most evident for women who have been visited by a family planning worker and have attended a health facility. Women age 15-19 appear to be in need of opportunities to discuss family planning.

Table 3.7 also reveals an association between educational level and the likelihood that a woman not using contraception will receive family planning advice; however, the association is not a simple one. In both the pilot and the control districts, nonusers with more education are more likely than those with less education to have been visited by a family planning worker. More educated nonusers are also more likely to have discussed family planning at a health facility, *but this holds only if they reside in the control districts*. More educated nonusers in the pilot districts, if they did not receive a visit by a family planning worker but they did attend a health facility, were *less* likely than less educated nonusers to have discussed family planning. Because of this, more educated nonusers in the pilot districts are more likely than less educated women to have not received any family planning contact at all in the preceding 12 months. The reverse is true in the control districts. This unusual finding should be interpreted with caution since the number of cases on which it is based is small.

3.7 Attitudes of Women Toward Family Planning

FPRHS respondents were asked if they approved of family planning. Table 3.8 shows the responses of women who were currently married and who knew at least one method of family planning. In both the pilot and the control districts, 89 percent of women reported that they approve of family planning. Amongst individual districts, there are few differences except that Chiradzulu and Mulanje districts in the Southern Region have slightly higher levels of approval than the other districts.

Table 3.8 Approval of family planning

Percentage of currently married women who approve of family planning by age, education, and residence (pilot/control district), Malawi 1999

Background characteristic	District						Residence	
	Chitipa (P)	Karonga (C)	Ntchisi (P)	Dowa (C)	Chiradzulu (P)	Mulanje (C)	Pilot district	Control district
Age								
15-19	73.5	82.5	78.8	72.5	86.2	88.4	77.7	81.5
20-24	90.1	92.9	92.5	90.8	94.1	93.3	91.9	92.4
25-29	92.9	89.5	91.0	89.9	88.9	91.9	91.1	90.3
30-34	88.7	84.2	92.2	89.0	95.7	97.9	91.9	89.8
35-39	84.4	83.9	89.5	88.9	97.9	89.7	89.9	87.5
40-44	84.6	80.0	94.6	82.6	100.0	92.1	93.8	85.4
45-49	73.3	70.8	80.0	85.3	100.0	92.9	80.8	83.7
Education								
No education	75.0	74.2	84.6	86.2	92.6	90.5	84.9	85.8
Primary	87.2	88.5	92.2	87.4	94.3	93.1	90.5	89.4
Secondary+	92.1	88.9	100.0	100.0	95.5	100.0	94.7	94.9
Total	85.6	86.4	89.6	87.5	93.8	92.4	89.2	88.6
Number of women	423	387	360	378	320	363	1,103	1,128

A woman's attitude toward family planning is related to her age, with women age 20-29 more likely to approve of family planning than younger and older women. The lower level of approval in the 15-19 age group could be due in part to the relative lack of exposure to family planning advice noted for this group in Table 3.7. Also, it should be noted that, since fewer of these women are married, it may be that they have personalized the survey question and simply do not approve of family planning use *at this time in their life*. At any rate, Table 3.8 provides further evidence of the need to target the youngest age group so that they are able to make appropriate choices about regulating fertility before they get into their most active child-bearing

years. Older groups also need to be targeted so that they can make reasonable decisions regarding the termination of childbearing.

Table 3.8 indicates that, in all districts, approval of family planning rises with increasing level of education. This finding supports the hypothesis that formal education empowers women to appreciate the value of smaller family size and creates a demand for family planning.

CHAPTER 4

FERTILITY PREFERENCES

In the FPRHS, women were asked about their preferences concerning having a child in the future and the length of time before having a child. Women who stated a preference for not having a child and who were not using contraception were asked why they were not using a family planning method.

The interpretation of survey data on fertility preferences is often difficult, since it is understood that respondents' reported preferences are, in a sense, hypothetical and thus subject to change and rationalisation. Still, the utility of information on the desire for children to anticipate changes in actual fertility behaviour (i.e., adoption of contraception) has been demonstrated in a wide variety of contexts.

4.1 Fertility Preferences of Currently Married Women by Number of Living Children

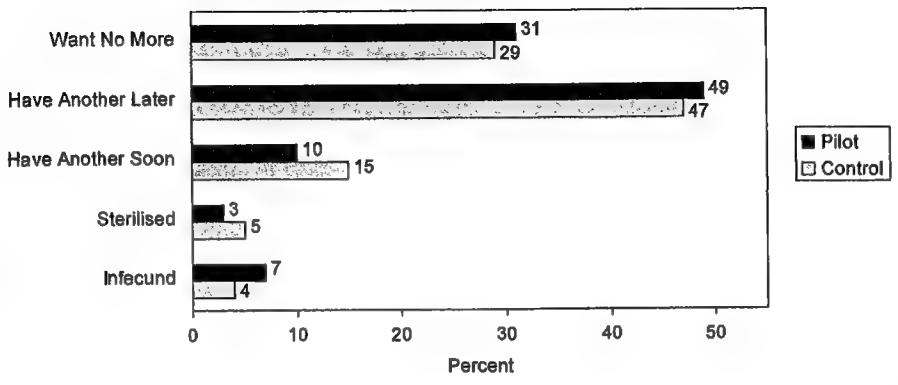
Women who were not sterilised were asked if they would like to have a child or, if they had already given birth, whether they would like to have another child. If they stated that they would like to give birth, they were then asked how long they would like to wait before doing so. Table 4.1 and Figure 4.1 present fertility desires of respondents according to number of living children and residence (pilot/control district).

Table 4.1 Fertility preferences by number of living children

Percent distribution of currently married women by desire for children, according to number of living children and residence (pilot/control district), Malawi 1999

Desire for children	Number of living children							Total
	0	1	2	3	4	5	6+	
PILOT DISTRICT								
Have another soon	35.2	10.9	10.9	6.3	9.6	3.2	2.0	9.9
Have another later	45.7	73.3	63.7	56.6	31.1	29.6	14.9	45.1
Have another later, undecided when	5.7	4.8	3.1	2.1	4.4	3.2	1.5	3.4
Want no more	4.8	4.8	15.5	28.0	42.2	50.4	64.9	31.3
Sterilised	2.9	0.0	1.0	2.8	3.0	4.0	7.4	3.1
Declared infecund	5.7	6.1	5.7	4.2	9.6	9.6	9.4	7.2
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Number of women	105	165	193	143	135	125	202	1,068
CONTROL DISTRICT								
Have another soon	42.0	22.1	15.8	9.7	6.6	4.8	2.1	14.6
Have another later	41.3	66.7	59.5	56.8	39.4	25.8	14.3	45.0
Have another later, undecided when	5.8	0.5	4.5	1.1	0.7	0.0	0.5	1.9
Want no more	6.5	7.2	16.7	25.0	41.6	55.6	60.8	29.2
Sterilised	0.0	0.0	1.4	2.3	8.0	10.5	13.8	4.8
Declared infecund	4.3	3.6	2.3	5.1	3.6	3.2	8.5	4.4
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Number of women	138	195	222	176	137	124	189	1,181

Figure 4.1
Percent Distribution of Currently Married Women Age 15-49, by Desire for More Children and Residence (pilot/control district)



Fifty-eight percent of married women in the pilot districts and 62 percent in the control districts reported that they wanted to have another child soon or later. However, only 10 percent of these respondents in the pilot districts and 15 percent in the control districts stated that they would like to have one soon (in the next two years), while 45 percent of respondents in both the pilot and the control districts expressed a desire to delay pregnancy beyond two years. Thirty-one percent of women in the pilot districts and 29 percent in the control districts stated that they wanted no more children. This means that 76 percent of currently married women in the pilot districts and 74 percent in the control districts would like either to delay or to prevent a pregnancy, and are currently in need of either a temporary or a permanent means of fertility control.

As expected, in both the pilot and the control districts, the desire to *space* the birth of a child declines with increasing number living children. On the other hand, the expressed desire to cease childbearing altogether (i.e., to *limit* childbearing) increases sharply with the number of living children. The net effect of these two patterns is that, once childbearing begins, the proportion of women falling into one or the other groups (spacers or limiters) is roughly constant across parity at 73 to 84 percent in the pilot districts and 74 to 82 percent in the control districts.

CHAPTER 5

AIDS KNOWLEDGE AND PREVENTION

Acquired immune deficiency syndrome (AIDS) is recognized as an important public health problem in Malawi. Accordingly, prevention campaigns for AIDS have been launched throughout the nation by MOHP through the National AIDS Control Programme (NACP). AIDS programmes are also being implemented by the Ministry of Education and Culture, the Ministry of Women and Children's Affairs, and various non-governmental organizations (NGOs). Condoms are being made available by means of free distribution and social marketing.

5.1 Knowledge of HIV/AIDS

The FPRHS asked respondents if they had ever heard of a virus called HIV or an illness called AIDS. The findings on general knowledge of HIV/AIDS are given in Table 5.1. In both the pilot and the control districts, the prevalence of knowledge is 98 percent for all women. In the 1996 MKAPH, 96 percent of rural women reported knowledge of HIV/AIDS. While general knowledge is high in all sub-populations, women age 15-19, never-married women, and women with no education are more likely than other women to know nothing of HIV/AIDS.

Table 5.1 General knowledge of HIV/AIDS

Percentage of women who know of HIV/AIDS by background characteristics and residence (pilot/control districts), Malawi 1999

Background characteristic	Pilot district		Control district	
	Knows of HIV/ AIDS	Number of women	Knows of HIV/ AIDS	Number of women
Age				
15-19	95.5	335	97.0	363
20-24	98.2	387	98.8	416
25-29	99.0	291	97.6	287
30-34	97.9	189	98.1	208
35-39	97.4	189	98.0	201
40-44	97.5	119	100.0	113
45-49	99.2	127	95.7	116
Marital status				
Currently in union	98.5	1,237	98.0	1,273
Formerly in union	98.0	153	99.5	194
Never married	93.1	247	96.2	237
Education				
No education	96.0	403	96.4	441
Primary	98.1	1,091	98.2	1,132
Secondary+	99.3	143	100.0	131
All women	97.7	1,637	97.9	1,704

5.2 Knowledge of Ways to Avoid HIV/AIDS

Knowledge that AIDS can be prevented is widespread in Malawi. Respondents were asked if AIDS can be avoided. As seen in Table 5.2, 94 percent of women in the pilot districts and 93 percent in the control districts reported that AIDS can be prevented. Next, respondents were asked to name specific ways to avoid getting the disease. The most commonly mentioned way to avoid AIDS was abstaining from sex, cited by 96 percent of respondents in the pilot districts and by 97 percent in the control districts. Limiting sex to one faithful partner was mentioned by 90 percent of respondents in the pilot districts and 91 percent in the control districts. Eighty-seven percent of respondents in the pilot districts and 88 percent in the control districts cited using condoms as a method of prevention.

Table 5.2 Knowledge of ways to avoid HIV/AIDS

Among women who reported knowing a way to avoid HIV/AIDS, the percentage knowing specific ways, by residence (pilot/control district), Malawi 1999

Question/response	Residence: Pilot district	Residence: Control district
Can AIDS be avoided?		
Yes	94.1	92.8
No	3.3	2.5
Don't know	2.7	4.7
Number of women	1,599	1,668
How can AIDS be avoided?		
Abstain from sex	95.5	96.6
Use condoms	87.4	87.6
Limit sex to one partner/stay faithful to one partner	90.3	90.7
Limit number of sexual partners	12.1	6.8
Avoid sex with prostitutes	20.7	15.8
Avoid sex with persons who have many partners	14.6	11.6
Avoid sex with homosexuals	3.5	1.4
Avoid sex with persons who inject drugs intravenously	4.3	1.2
Avoid blood transfusions	13.0	7.6
Avoid injections	23.8	21.6
Avoid kissing	4.1	2.9
Avoid mosquito bites	22.7	33.3
Seek protection from a traditional healer	7.2	2.0
Avoid sharing razors/blades	40.3	42.1
Do not share food with someone who has AIDS virus	17.2	24.0
Other	0.3	1.0
Does not know a specific way	0.1	0.1
Number of women	1,504	1,548

5.3 Knowledge of Programmatically Important Ways to Avoid AIDS

In preventing transmission of the AIDS virus, some methods are more important or effective as public health measures than others. Table 5.3 and Figure 5.1 show the proportion of respondents who mentioned spontaneously, or affirmed when prompted, one or more of the following ways to avoid HIV/AIDS: abstain from sex, use condoms, limit sex to one partner, and limit the number partners. Table 5.3 and Figure 5.1 also show that 18 percent of respondents in both the pilot and the control districts knew two of these ways, while 71 percent knew three or more ways.

Studies in several African countries have shown that prompted questions on ways to avoid AIDS can clarify in a respondent's mind her knowledge and beliefs concerning the effectiveness of the methods. Table 5.3 shows the proportion of respondents who cited "condoms" and "limiting sex partners" as ways to avoid AIDS, when specifically asked about the effectiveness of these methods. Ninety percent of women in the pilot districts and 89 percent of women in the control districts replied in the affirmative when asked whether condoms could protect against transmission of the AIDS virus. Even larger proportions of respondents cited limiting the number of sex partners as being effective. Ninety-two percent of respondents in the pilot districts and 91 percent in the control districts affirmed the effectiveness of partner limitation when asked about it. In general, knowledge of valid ways to avoid AIDS is very high in the PFPP study area.

5.4 Knowledge of Issues Related to Transmission of the AIDS Virus

Table 5.4 and Figure 5.2 show the proportion of respondents who were aware of the fact that a healthy-looking person can harbor the HIV virus and that HIV can be transmitted from mother to child. Knowing that healthy looks can be deceiving may constrain people from having sexual intercourse with persons whose HIV status they do not actually know. Knowledge of mother-child transmission may persuade women to be more careful about avoiding the risk of infection, while those women who know that they have HIV may adopt effective measures to prevent pregnancy. Eighty-six percent of women in the pilot districts and 85 percent in the control districts knew that a healthy-looking person can have the AIDS virus. Eighty-nine percent of women in the pilot districts and 88 percent in the control districts were aware that a mother can transmit the AIDS virus to a newborn child.

Table 5.3 Knowledge of specific ways to avoid getting the AIDS virus

Percent distribution of women by knowledge of programmatically important ways to avoid AIDS, according to residence (pilot/control district), and percentage of women with knowledge (prompted) of specific ways to avoid AIDS, Malawi 1999

	Knowledge of programmatically important ways to avoid AIDS[1]							Knowledge of specific ways to avoid AIDS (prompted)[2]		
Residence	Does not know AIDS	Knows AIDS, but cannot name any means to avoid it	Knows one way to avoid AIDS	Knows two ways to avoid AIDS	Knows three or more ways to avoid AIDS	Total	Number of women	Use condoms	Limit number of sex partners	Number of women
Pilot district	2.3	6.0	2.7	17.6	71.3	100.0	1,637	89.5	91.6	1,470
Control district	2.1	7.2	2.1	17.7	70.8	100.0	1,704	89.3	91.1	1,518

[1] Includes abstaining from sexual intercourse, using condoms, limiting the number of sex partners, and staying faithful to one partners or limiting sex to one partner.
[2] Respondents were "prompted" regarding use of condoms and limiting sex partners, by specifically asking them if these methods could protect a person from getting the AIDS virus.

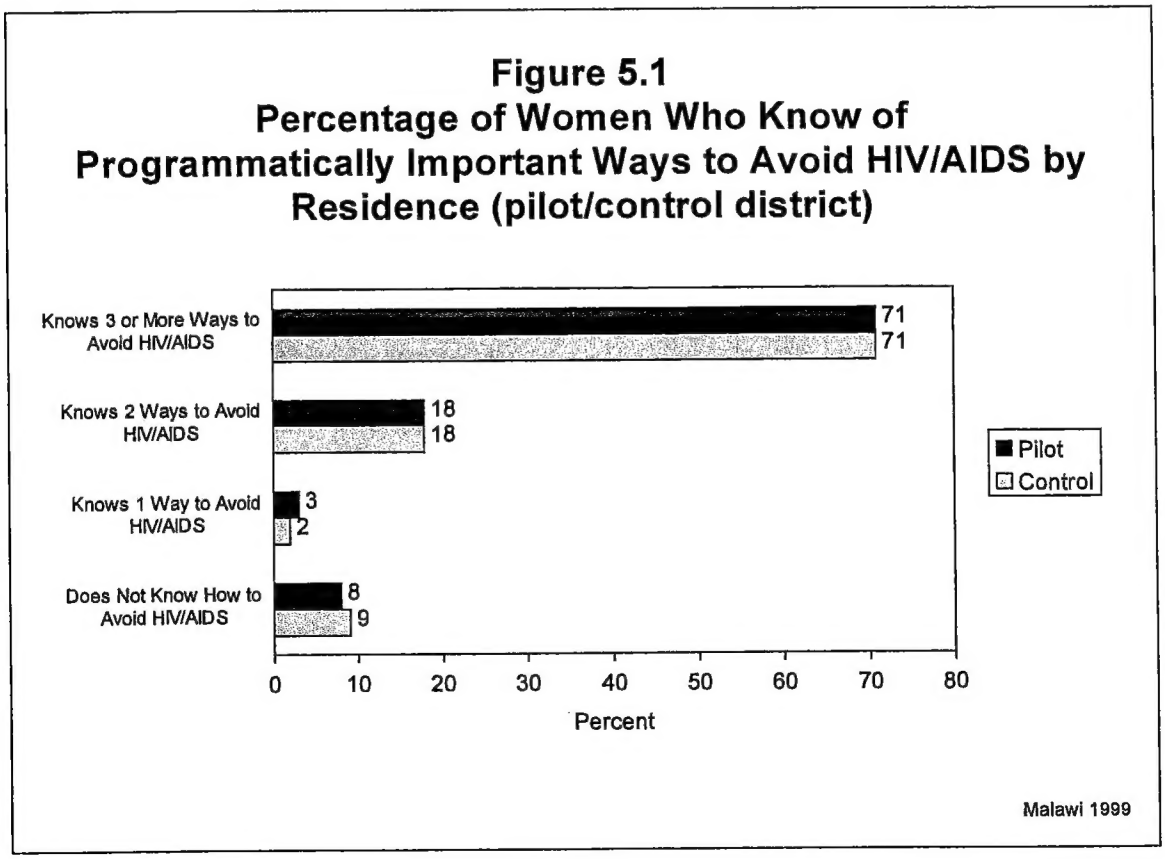
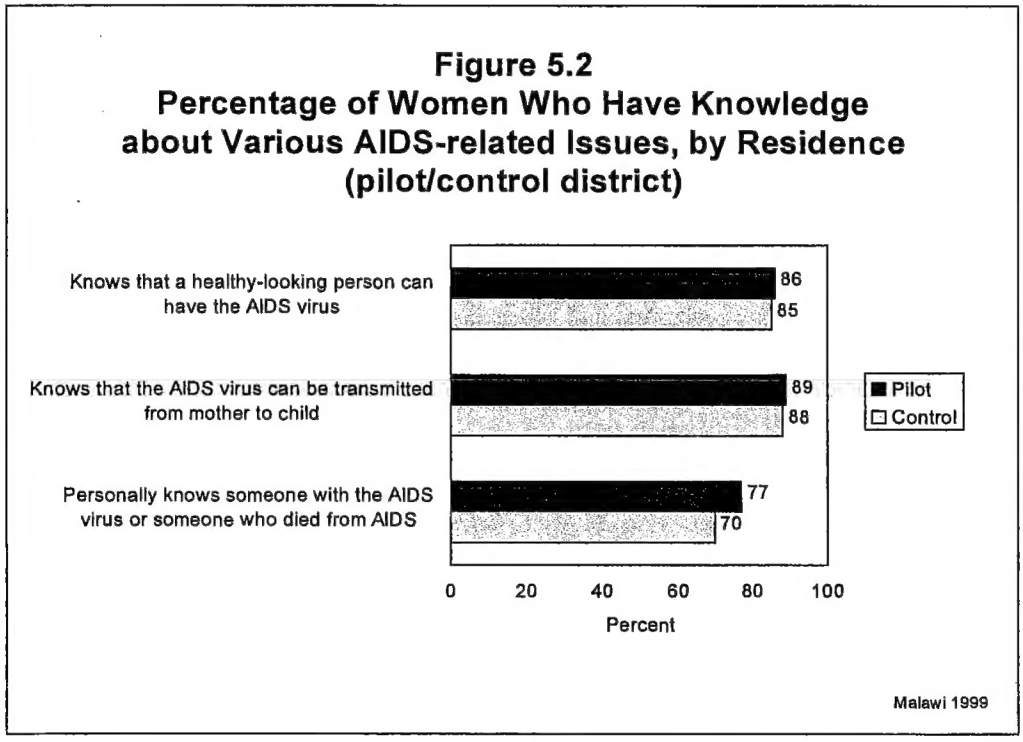


Table 5.4 Knowledge of AIDS-related issues

Percentage of women who know of HIV/AIDS by responses to questions on various AIDS-related issues and residence (pilot/control district), Malawi 1999

Residence	Can a healthy-looking person have the AIDS virus?				Can the AIDS virus be transmitted from mother to child?				Personally knows someone with the AIDS virus or who died of AIDS			Number of women
	Yes	No	Don't know	Missing	Yes	No	Don't know	Missing	Yes	No	Missing	
Pilot district	86.0	8.9	4.2	0.9	89.2	7.3	3.4	0.2	76.7	22.9	0.4	1,599
Control district	85.1	9.7	5.0	0.2	87.6	6.8	5.4	0.2	70.4	29.5	0.1	1,668



Knowing someone who has AIDS or has died of AIDS, and therefore knowing the suffering AIDS patients endure, may encourage risk avoidance. Seventy-seven percent of women in the pilot districts knew someone with AIDS, compared with 70 percent in the control districts. The fact that around 3 in 4 women have personal experience with an AIDS victim emphasizes the enormous social impact of the AIDS epidemic in Malawi.

5.5 Knowledge of a Source for Condoms

As seen in Table 5.5, 74 percent of respondents said that they knew of a source of supply for condoms in the pilot districts compared with 71 percent of women in the control districts. Of those women who reported that they knew a source for condoms, 92 percent in the pilot districts and 84 percent in the control districts named a public source for condoms. Only 5 percent of respondents in the pilot districts and 10 percent in the control districts named a private medical source.

Table 5.5 Knowledge of a source for condoms

Percentage of women who know of a source for condoms, and percentage who know of specific types of condom sources, by residence (pilot/control district), Malawi 1999

Residence	Knows any source for condoms	Number of women	Type of source for condoms				
			Public	Private medical	Other private	Missing	Number of women
Pilot district	74.3	1,637	91.5	5.0	3.5	2.2	1,216
Control district	70.9	1,704	84.2	10.0	5.8	0.4	1,208

5.6 Use of Condoms during Last Sexual Intercourse

The FPRHS asked all women who had had sex in the last 12 months whether they used a condom the last time they had sex. Table 5.6 shows that 12 percent of women in the pilot districts and 11 percent of women in the control districts used a condom at last sex. The expected associations with age, marital status, and education are seen. Women with a secondary level of education are nearly 4 times more likely to have used a condom at last sex than their counterparts with no formal education. This suggests that, to a greater extent than among uneducated women, women with education possess the knowledge and skills to negotiate safer sex practices.

Table 5.6 Use of condoms

Among women who had sex in the last 12 months, the percentage who used a condom at last sex, by background characteristics, Malawi 1999

Background characteristic	Used condom at last sex	Number of women
Age		
15-19	18.1	343
20-24	14.7	599
25-29	10.6	470
30-49	6.4	864
Residence		
Pilot district	11.6	1,082
Control district	10.9	1,194
Marital status		
Currently in union	9.5	1,996
Not currently in union	23.6	280
Education		
No education	6.3	554
Primary	11.4	1,548
Secondary	24.7	174
All women	11.2	2,276